

## Underwriting Assessment



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**FORM 1 — APPLICATION AND MEDICAL QUESTIONNAIRE (To be completed by physician)**

10 23 MU1 ECA 1206 CLS

**For Broker or Sales Agent's use only:**

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Tel. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Part A CLIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth (d/m/y): \_\_\_\_\_ Tel. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

Travel Dates: Departure (d/m/y): \_\_\_\_\_ Return (d/m/y): \_\_\_\_\_ Trip Duration: \_\_\_\_\_ days

Exact Destination: City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**Personal information:** Your personal information is collected for the purpose of providing you with insurance services, claims analysis and payments. Call 1-800-680-3837 for a copy of the **etfs** Privacy Policy. For information, please see [www.royalsunalliance.ca](http://www.royalsunalliance.ca), or call us at 1-800-716-4339.

**Part B MESSAGE TO THE PHYSICIAN**

*In taking time to fill out this questionnaire\*, you are helping your patient to obtain the proper emergency health insurance while he/she is travelling. Proper coverage will safeguard your patient's financial security.*

The answers you provide regarding your patient's health status will help us to determine his/her eligibility to purchase travel insurance. Although he/she does not qualify for our regular insurance plan, we may be able to offer the applicant a modified travel insurance program.

Please include any relevant information you feel may help us assess this patient's medical stability. If you feel your patient's condition is too unstable for him/her to travel this year, please discuss this matter with him/her and advise us in Part D - Comments. We appreciate your cooperation.

**\*Charges levied for the completion of this document remain the patient's responsibility.**

**Part C QUESTIONNAIRE (Please type or print clearly)**

List all diagnoses and medical and/or surgical conditions	Date of initial presentation	List all current medications	Date of initial prescription	Medication changes (including dosage and date) during past year

1. Does your patient take **Lasix or other diuretic**?  yes  no If yes, what dosage? \_\_\_\_\_  
 If so, for what condition?  CHF  HTN  Peripheral Edema  Other (please specify): \_\_\_\_\_
2. Does your patient take an **ACE-inhibitor**?  yes  no  
 If so, for what condition?  CHF  HTN  Other (please specify): \_\_\_\_\_
3. List any other therapy required during the past 3 years (e.g. home oxygen, chemo, radiation therapy, etc.).  
 Therapy: \_\_\_\_\_ Date (or period of treatment): \_\_\_\_\_  
 Therapy: \_\_\_\_\_ Date (or period of treatment): \_\_\_\_\_  
 Therapy: \_\_\_\_\_ Date (or period of treatment): \_\_\_\_\_
4. List all hospitalizations during the past 3 years.  
 Date of hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date of hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Date of hospitalization: \_\_\_\_\_ Diagnosis: \_\_\_\_\_
5. List all major tests and investigations during the past 2 years (e.g. cardiac stress test, cardiac catheterization, scans). **Please include a copy of the test results.**  
 List other recent significant tests (e.g. Hgb for anemia, creatinine for renal insufficiency, LFTs for cirrhosis, etc.).  
 Test/investigation: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Test/investigation: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Test/investigation: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
**Ejection fraction** (if known): \_\_\_\_\_ % Date: \_\_\_\_\_ **Smoking status:**  yes  no

6. Is the patient awaiting investigations, surgery or any other treatment?  
 yes  no If so, please specify the **type** and the **date**: \_\_\_\_\_

7. Has your patient ever undergone a **Coronary Artery Bypass Graft**?  yes  no Date (m/y) \_\_\_\_\_  
**Angioplasty**?  yes  no Date (m/y) \_\_\_\_\_  
**Stenting**?  yes  no Date (m/y) \_\_\_\_\_

8. Has the patient ever had a functional **cardiac classification** for **Angina**? ...  yes  no  
 If so, what is the patient's **CURRENT class** of **Angina**? .....  I  II  III  IV Date of last episode (d/m/y): \_\_\_\_\_

9. Has the patient ever been diagnosed or treated for **Congestive Heart Failure**? .....  yes  no  
 If so, what is the patient's **CURRENT class** of **Congestive Heart Failure**?  I .....  II  III  IV Date of last episode (d/m/y): \_\_\_\_\_

**Part D** **COMMENTS**

\_\_\_\_\_

\_\_\_\_\_

**Part E** **PHYSICIAN INFORMATION**

How long has the applicant been your patient? Since (d/m/y)? \_\_\_\_\_ Are you this patient's family physician, specialist or other? \_\_\_\_\_

Physician's name: \_\_\_\_\_ Address: \_\_\_\_\_

Prof. No.: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**THIS FORM MUST BE RETURNED TO THE ADDRESS OR FAX NUMBER INDICATED ON THE FRONT OF THIS FORM.**